Introduction to Spine Coding: The Four Elements

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Disclaimer

• The following presentations are not to be considered a replacement for the Current Procedural Terminology (CPT) book or the International Classification of Diseases 9th Revision-Clinical Modification (ICD-9-CM) book. It is designed simply as a resource to help you obtain a better understanding of spine coding. Always refer back to the full Current Procedural Terminology (CPT) book when coding.

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The Four Elements of Spine Coding

WHY: The diagnosis; the reason for the surgery.

HOW: How are you getting there, what approach?

WHERE: Where is the anatomical location?

WHAT: What is it that you are doing?
The Four Elements of Spine Coding

Primary Diagnosis
Main Approach
Main Location
Main Procedure

Coding descriptors do not necessarily follow the surgeon’s vernacular.

PRIMARY DIAGNOSIS
ICD-9-CM Primary Diagnosis

This reference material is the responsibility of the World Health Organization. And their main responsibility is to track diseases and illnesses throughout the world.

Primary Diagnosis

- Lesion
- Neoplasm
- Deformity
- Spinal Condition
Primary Diagnosis

Neoplasm - new and abnormal growth of tissue, eg: malignant tumors

Lesion - Any pathological or traumatic discontinuity of tissue or loss of function of a part, eg: infections

Deformity - A permanent structural deviation from the normal shape or size, eg: scoliosis, kyphosis, etc

Spinal Condition - Spine related condition, eg: stenosis, disc herniation, spondylosis, etc

Neoplasm vs. Spinal Condition

Corpectomy for Myelopathy:
Cervical Spine Code 63081
ICD-9  721.1

Corpectomy for Neoplasm:
Cervical Spine Code 63300
ICD-9  198.5
Neoplasm vs. Spinal Condition

Lumbar Laminectomy for Lesion other than Herniated Disc
CPT Code: 63267
Diagnosis Osteomyelitis: 730.20

Lumbar Laminectomy including Laminectomy, Facetectomy, and Foraminotomy
CPT Code: 63047
Diagnosis: Spinal Stenosis: 724.02

Fusion Revision Surgery vs. Deformity Correction

Flat back syndrome, recurrent spinal stenosis, painful hardware:
ICD-9 722.83, 724.02, etc

Coding ranges include decompression and fusion coding at each level:
i.e.: 63042, 63044, 22612, 22614, etc.

Adolescent/ adult idiopathic scoliosis:
ICD-9 737.30

Coding range is limited to very specific code groupings for deformity:
i.e.: 22800 or 22810 or 22812, etc.
MAIN APPROACH

Main Approach
Anterior  Posterior  Extracavitary Lateral

Images of anterior, posterior, and extracavitary lateral approaches to the spine.
Main Approach

Coding designated by approach, regardless of where you end up

For example:
No posterior corpectomy codes
Anterior interbody fusion is not possible via posterior approach

Multiple Approaches

Each approach should have its own operative note.

i.e. anterior/posterior procedures require separate operative reports.
Anterior

1. Anterior/Lateral
2. Transthoracic
3. Thoracolumbar
4. Retroperitoneal

Anterior

1. Anterior Lateral 63300
2. Transthoracic 63301
3. Thoracolumbar 63302
4. Retroperitoneal 63303
**Posterior**

1. Posterior Lateral
2. Transpedicular
3. Costovertebral

**Extracavitary Lateral**

1. Thoracic
2. Lumbar
Main Location

- Cervical
- Thoracic
- Lumbar
- Sacral
Main Location

- Cervical
- Thoracic
- Lumbar
- Sacral

State All Levels and Interspaces

Example:

T5 – L3 fusion for deformity.

NOT thoracolumbar fusion for deformity.
Properly Identify the Exact Location

Using the basic concept of labeling, referencing the exact anatomical location, is critical to the coding process.

Vertebral Interspaces with a “-”
i.e.: C3-C4, C4-C5 for interspaces for discectomies.

Vertebral Segments with “,”
i.e.: C3, C4, C5 for segments of corpectomies.
Properly Identify the Exact Location

Vertebral interspaces with “-”

i.e.: T3-T4, T4-T5 for interspaces for discectomies.

Vertebral segments with “,”

i.e.: T3, T4, T5 for segments of corpectomies.

Identify Different Locations Properly

Example 2: Patient has severe Spondylosis and Disc Herniation from C3-C6

Operative note indicates the “Procedures Performed”

- Cervical Discectomy
- Cervical Corpectomy

In this case, codes are considered *bundled.*
Identify Different Locations Properly

Further clarification allow for appropriate coding of “Procedures Performed”

- Cervical Discectomy C3 – C4: 63075
- Cervical Corpectomy C5, C6: 63081, 63082

In this case, codes are considered not bundled, as they are at different levels.

*Carrier rules apply

Identify Different Locations Properly

Examples: Patient has disease from L3-S1

- Op notes states “Procedure Performed”
  - Lumbar Interbody Fusion
  - Lumbar Lateral Fusion
  - Lumbar Laminectomy

Coding could be of many different combinations
Identify Different Locations Properly

Further clarification indicates that the “Procedures Performed”

- Lumbar Interbody Fusion L4-L5: 22630
- Lumbar Lateral Fusion L4-S1: 22612, 22614
- Lumbar Laminectomy L3,L4,L5: 63047, 63048 X 2*

In addition, there were additional implants, grafts and instrumentation utilized.

*Carrier rules apply

MAIN PROCEDURES
Main Procedures

Decompression
Fusion
Grafting
Instrumentation
Exploration
Osteotomies
Fracture Treatment
Injections
Miscellaneous

Main Procedures: Account for Everything

*Example:*
Decompression
Lateral Fusions
Interbody Fusion
Instrumentation
Implants
Grafts
Main Procedures: Decompressions

Decompressions

Coding is based on the interspace and levels and degree of decompression and are certainly diagnosis based.

Most difficult coding in Spine
There are several types of decompressions that may be performed during the surgical session.

*The main coding difficulty lies in the language used by the surgeon to describe the type and location.*

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**Main Procedures: Decompressions**

Most difficult to decipher. Extent and diagnosis based.

**Coding Examples Represent Cervical Procedures:**

- **Laminotomy:** 63020, 63040
- **Laminectomy:** 63001, 63015, 63045, 63265, 63275
- **Corpectomy / Vertebrectomy:** 63081, 63300, 63304
- **Laminoplasty:** 63050, 63051
Main Procedures: Decompressions

Laminectomy or Corpectomy for:

- Spinal Condition
- Neoplasm
- Lesion

Diagnosis and location will determine the appropriate code

Main Procedures: Types of Decompression

✓ Corpectomies: The 50/30 rule:
  - 50% removal for cervical
  - 30% removal for Lumbar

✓ No anterior discectomy code for cervical or lumbar in combination with a fusion

✓ The diagnosis and degree of decompression will determine the code selection
Main Procedures:
Fusion/Decompression Changes

Cervical fusion and discectomy

CPT CODES 22551 & 22552 replace the use of codes 63075 with 22554 and 63076 with 22585 when performed in combination with surgeons or co-surgeons.

MAIN PROCEDURE
FUSION
Main Procedures: Fusion

Differentiation of Reconstructive Procedure vs. Corrective Procedure vs. Stabilizing Procedure:

Lateral Deformity Interbody

Document and code for exploration

Main Procedures: Fusion

Clarity in the fusion procedure is absolutely necessary to code.

The cases that involve reconstruction and revision must be documented as such and should not be considered a deformity unless it is a pure scoliosis or kyphosis case for curve correction.
Main Procedures: Fusion

Number of Levels and Location Matters

- Lateral: 22600-22614
- Deformity: 22800-22818
- Interbody: 22554-22585, 22630-22632
- Specific areas of fusion: 22590-22595

These are just examples of the numerous fusion codes available

Main Procedures: Types of Fusion

Although the term fusion should satisfy the documentation requirements, it is necessary to discuss the other components leading up to the “fusion” procedure.

Clearly dictate the levels of decortication and the subsequent laying of graft or other materials to support the coding
Main Procedures: Types of Fusion

Describe all the types of fusions performed in the operative session.

Do not make the assumption that the reviewer or coder will know exactly where and what type of fusion was performed.

Count levels of fusion properly.
Main Procedures: Grafting

Autograft vs. Allograft

Structural vs. Non-Structural

Same-site, separate incision, bone products.

Account for all procedures performed.

Spine specific graft codes are in the 20930-20938 range

Main Procedures: Types of Grafting

Allografts

Autografts
Main Procedures: Types of Grafting

The type of grafting matters as the coding changes based on the graft materials used.

There are so many different products or grafting possibilities that the coder may not even know that the opportunity to code is there without guidance.

Main Procedures: Types of Grafting

and don’t forget bone marrow aspiration.
Main Procedures: Instrumentation

- Insertion, removal, reinsertion
- Plating, pedicle screws, rods, etc.
- Identify segmental vs. Non-segmental
- Identify all levels of placement
- Identify by brand name
Main Procedures: Instrumentation

Non-segmental Instrumentation: Posterior: 22840
Segmental Instrumentation: Posterior: 22842-22844
Spinous Process Wiring: Posterior: 22841
Biomechanical Devices: Anterior/Posterior: 22851
Anterior Instrumentation: Anterior: 22845-22847
Pelvic Instrumentation: Posterior: 22848

Main Procedures: Types of Instrumentation

Instrumentation is billed by “construct” type, and notably by the number of levels or interspaces involved, along with the anatomical placement of the instrumentation.
Main Procedures: Types of Instrumentation

Nonsegmental vs Segmental Instrumentation

Posterior Only:
Noted by the specific areas where the attachments are made.

Main Procedures: Types of Instrumentation

Code 22851

Biomechanical device codes are billable for each interspace where implants are placed.
Main Procedures: Types of Instrumentation

Bill all of the instrumentation for the case.

Main Procedures: Instrumentation
Removal / Insertion / Reinsertion

There are codes available for all of these procedures.

*It is necessary to document properly, as they are not billable in certain combinations.*

Coding Includes:

- 22849 Reinsertion of Instrumentation
- 22855 Removal of Anterior Instrumentation
- 22850 Removal of Posterior Non-Segmental Instrumentation
- 22852 Removal of Posterior segmental Instrumentation
Main Procedures: Osteotomy

Anterior and Posterior
Account for all segments by anatomical location
Often performed with fusion for deformity correction.
Can bill for both anterior and posterior osteotomy procedures

Do not bill decompression codes at the same level

Main Procedures: Osteotomy

Code for Both Types

Smith Peterson
22212-22226

Pedicle Subtraction
22206-22208

Do not bill decompression codes at the same level.
Main Procedures: Types of Fracture Treatment
## Main Procedures: Fracture Treatment

**Open and closed coding opportunities**

Document and dictate both when applicable account for all levels.

Do not bill decompression with fracture codes

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Codes</th>
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</thead>
<tbody>
<tr>
<td>Corpectomy codes</td>
<td>63081-63091</td>
</tr>
<tr>
<td>Ondontoid Fracture Codes</td>
<td>22318 &amp; 22319</td>
</tr>
</tbody>
</table>

**Fracture codes**

- **Closed procedures**: 22305-22315
- **Posterior procedures**: 22325-22328
Main Procedures: Fracture Treatment

Corpectomy codes for anterior fractures 63081-63091

Code for the fusion, instrumentation and other associated procedure codes

Main Procedures: Fracture Treatment

Fracture codes for open posterior procedures 22325-22328

Code for the fusion, instrumentation and other associated procedure codes
Miscellaneous Coding

Kyphoplasty
Vertebroplasty
Arthroplasty
Stimulators
Excisions
Infection
Biopsy
Injections
Fluoroscopy
Halo/Tongs
Microscope

Miscellaneous Procedures: Kyphoplasty Vertebroplasty

Code for all levels and be sure to have the preoperative documentation in order
Codes 22520- 22525

CT or Fluoro Imaging Codes 72291- 72292
**Miscellaneous Procedures: Arthroplasty**

Identify procedure by
- Insertion**
- Removal
- Revision

Code for both anterior
- Codes 22856-22865
  - 0092T-0098T
and posterior
- Codes 0200T-0222T

**Includes the discectomy

**Miscellaneous Procedures: Stimulators**

Includes coding for
- Insertion
- Removal
- Revision

And for the programming of the generators, etc

Codes 63650-63688
**Miscellaneous Procedures: Excisions**

Rarely used
For removal of anterior or posterior bony component due to lesion without decompression of spinal cord or nerve roots

Code 22100-22114

**Miscellaneous Procedures: Infection**

Infection coding is specific to anatomical region:

- Cervical and thoracic 22010
- Lumbar 22015

Cannot code with Removal of instrumentation Codes

Code 10180: Post operative Wound Infection
Miscellaneous Procedures: Biopsy

Code by location and type of biopsy required

Considered inclusive to other global procedures

Codes 20200-20251

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Miscellaneous Procedures: Injections

Many coding changes in this area on a continuous basis

Follow carrier guidelines on a regular basis

Document medical necessity and results on a procedural basis
**Miscellaneous Procedures: Fluoroscopy**

Many carriers and societies consider fluoroscopy included in the surgical procedure if the surgeon is doing the actual reading in real time.

This coding opportunity presents itself in both the injection and “plasty” procedures.

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**Miscellaneous Procedures: Halo/Tongs**

Coding is available for these procedures and may or may not be covered based on carrier guidelines.
Code 20660-20661

Often considered part of a more global procedure.
Miscellaneous Procedures: Microscope

Indicating the need and documenting that a microscopic dissection was performed is absolutely necessary.

Code 69990

Mastering Modifiers
Mastering Modifiers

Spine coding is one of the most challenging disciplines within the medical field.

There are tools available, that, *when used properly*, can *significantly* increase your chances for a successful outcome on your claim.

These tools are called … **Modifiers**.

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Mastering Modifiers

What are *modifiers* and how do they affect spine reimbursement?

Modifiers are *2 digit numbers added to the end of your AMA CPT codes*, used to manipulate or further clarify a procedure’s description.

Modifiers *allow for the reporting of a service or procedure that has been altered by some specific circumstance*, but not change the definition or code.
Mastering Modifiers

The simplest way to think of a modifier is as a communication tool.

Modifiers allow coders to communicate to insurance carriers that something is different about that particular encounter or claim.

The purpose of a modifier is to allow special consideration for payment.

Incorrect use or absence of modifiers, when appropriate, will result in reduced reimbursement or denial of the claim.

Mastering Modifiers

There are approximately 13 modifiers that can be applied to spine procedures on a regular basis.

Because of the complexity of some spine procedures, it is essential that you understand and use modifiers correctly.
Mastering Modifiers

The modifiers used to help code spine procedures are divided into 4 categories:

- Procedure
- Surgeon
- Complication
- Service

Procedure Modifiers

- 50 – Bilateral Procedure
- 51 – Multiple Procedures
- 52 – Reduced Procedures
- 53 – Discontinued Procedure
- 57 – Decision for Surgery
- 58 – Staged or Related Procedure
- 59 – Distinct Procedural Service
- 79 – Unrelated Procedure or Service by the Same Physician During the Post-Operative Period
50 Modifier Bilateral Procedure

AMA CPT Modifier Descriptor

Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding *modifier 50 to the appropriate 5 digit code.*

50 Modifier Bilateral Procedure

Modifier 50 is used to report a bilateral procedure, meaning a procedure performed on *both the right and left sides of the body.*

For spinal procedures, these codes are easily identified.

They are codes 63020 though 63044 for virgin and revision laminotomy codes:

63020..30..35..40..42..43..44
Carriers have specific guidelines for submission of their respective claims involving the -50 modifier. Investigating the coding requirements is recommended before submitting the claim.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lumbar Laminotomy Bilateral at L5-S1</td>
<td>63030-50</td>
</tr>
<tr>
<td>Lumbar Lateral Arthrodesis L5-S1</td>
<td>22612</td>
</tr>
<tr>
<td>Iliac Crest Graft</td>
<td>20937</td>
</tr>
</tbody>
</table>
When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (e.g., vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s).

Note: This modifier should not be appended to designated “add-on” codes.

When claims are submitted to the carrier, most insurance carriers will invoke the Multiple Procedure Reduction rule:

“The first primary procedure will be paid at 100% of the allowed amount and the subsequent primary procedures will be reduced to 50% of the allowed amount.”
51 Modifier Multiple Procedures

It is important that we understand the *Multiple Procedure Reduction rule*

Any primary procedure after the first primary procedure will be considered at a reduced rate, usually 50% of the payable fee schedule. Exempt codes are not subject to such a reduction.

*Carrier and policy conditions apply. Any further reductions should be scrutinized and appealed for proper payment.*

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51 Modifier Multiple Procedures

Exempt Codes: they are not subject to this reduction

Refrain from using this modifier with “in addition to” or “additional levels” codes:

- such as instrumentation, ie: 22840-22845
- grafting, ie: 20930-20938
- additional level codes for fusion and decompression procedures, ie: 22585, 22614, 63035, 63048
51 Modifier Multiple Procedures

<table>
<thead>
<tr>
<th>Description</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Removal of Posterior Non-Segmental Instrumentation</td>
<td>22850</td>
</tr>
<tr>
<td>At L5</td>
<td></td>
</tr>
<tr>
<td>Posterior Arthrodesis</td>
<td>22612-51</td>
</tr>
<tr>
<td>At L5-S1</td>
<td></td>
</tr>
<tr>
<td>Iliac Crest Graft</td>
<td>20937</td>
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</table>

52 Reduced Procedures

AMA CPT Modifier Descriptor

Modifier 52 Reduced Services: Under certain circumstances, a service or procedure is partially reduced at the physician's discretion. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of the modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Using this modifier does not reduce the allowance to the provider. Note: Modifier 52 may be used with computerized tomography procedure codes for a limited study or a follow-up study.
**52 Modifier Reduced Procedures**

Should be considered *only* when the procedure performed is noted in the AMA CPT descriptor but the entire procedure has not been completed.

*Rarely used in spine.*

This code is a *red light* for audits.
53 Modifier Discontinued Procedure

AMA CPT Modifier Descriptor
Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.

This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discounted procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient’s anesthesia induction and/or surgical preparation in the operating suite.

53 Modifier Discontinued Procedure

This modifier is for procedures that were attempted and discontinued due to the circumstances where the patient’s care was compromised and the surgeon elected to terminate the procedure during the operation. (i.e. excessive blood loss, cardiac event)

_The procedure does not have to be fully completed to receive compensation; ie discontinuing the interbody fusion due to difficulties in the preparation component._
53 Modifier Discontinued Procedure

Modifier 53 should not be used to describe the elective cancellation of a procedure before anesthesia or surgical preparation in the operating suite.

In most cases, if you have documented the event properly, you should get paid.

Bill the procedure at the full fee and allow the carrier to reduce as warranted. An appeal for low or denied payment may be required.
### 53 Modifier Discontinued Procedure

- **Anterior Cervical Decompression and Arthrodesis at C5-6 Discontinued due to Complications**
  - CPT Code: 22551-53

### 53 Modifier Discontinued Procedure

- **Anterior Cervical Decompression and Arthrodesis C5-6**
  - CPT Code: 22551

- **Anterior Instrumentation discontinued due to osteoporosis complications**
  - CPT Code: 22845-53

- **Iliac Crest Graft**
  - CPT Code: 20938
57 Modifier Decision for Surgery

AMA CPT Modifier Descriptor

An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

Decision to perform surgery is made during the Evaluation and Management service.

i.e.: Hospital consultation indicated a patient for surgery within 24 hours of visit.
57 Modifier Decision for Surgery

This modifier should be noted in the patient’s file immediately.

Your documentation should clearly indicate that the consultation or initial visit resulted in the decision to perform surgery within the next 24 hours.

The E/M code will require the application of the 57 modifier, not the surgical case.

Communicating this information before submission of the consultation code is critical.

<table>
<thead>
<tr>
<th>Inpatient Consultation request</th>
<th>99255-57*Carrier Specific</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterior Lumbar Arthrodesis at L5-S1</td>
<td>22558</td>
</tr>
<tr>
<td>Biomechanical Implant</td>
<td>22851</td>
</tr>
<tr>
<td>Iliac Crest Graft</td>
<td>20937</td>
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</tbody>
</table>
58 Modifier Staged or related procedure or service by the same physician during the post-operative period

AMA CPT Modifier Descriptor
It may be necessary to indicate that the performance of a procedure or service during the postoperative period was (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure.

58 Modifier Staged or related procedure or service by the same physician during the post-operative period

The 58 modifier does not apply to the original surgical procedure and should only be applied to subsequent staged surgical procedures.

Operative reports should clearly indicate that these cases are “staged” to alert the carrier and the staff to look for subsequent surgeries to follow.
58 Modifier Staged or related procedure or service by the same physician during the post-operative period

There should not be reduction in the reimbursement for subsequent procedures, but this is based entirely on *specific carrier regulations.*

*Scrutinize your EOB* to determine the payment rates that have been applied. Be sure to appeal if the payment includes any type of inappropriate of fee schedule reduction.

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<td>Iliac Crest Graft Bicortical or Tricortical</td>
<td>20938</td>
</tr>
<tr>
<td>Posterior Arthrodesis At L5-S1</td>
<td>22612-58 (different surgical session)</td>
</tr>
<tr>
<td>Non-Segmental Posterior Instrumentation</td>
<td>22840-58* (carrier specific)</td>
</tr>
<tr>
<td>Morselized Allograft</td>
<td>20936-58* (carrier specific)</td>
</tr>
</tbody>
</table>
A physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day.

*Modifier 59 is used to identify procedures or services that are not normally reported together, but are appropriate under the circumstances.*
59 Modifier Distinct Procedural Service

Used to unbundle codes that are typically considered inclusive to one another.

Examples would include cases such as:
Decompressive laminectomy was performed with an interbody fusion

Laminotomies are performed at different levels than other decompressions such as Laminectomies.

59 Modifier Distinct Procedural Service

You may use modifier 59 if several procedures are performed on different anatomical sites or at different operative sessions, but these procedures must be performed on the same day.
59 Modifier Distinct Procedural Service

Modifier 59 should be used with caution because it affects reimbursement and tells payers that, under distinct circumstances, it is appropriate to bill procedures as separate and distinct.

_This modifier is not designed to provide reimbursement for separate procedures that are performed as an integral part of another procedure and is watched closely by carriers._

Documentation needs to be specific to the distinct procedure or service and _clearly identified_ in the medical record.

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### 59 Modifier Distinct Procedural Service

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<thead>
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<tbody>
<tr>
<td>Exploration of Cervical Fusion @ C4-C5</td>
<td>22830-59</td>
</tr>
<tr>
<td>Anterior Cervical Decompression and Arthrodessis C5-6</td>
<td>22551</td>
</tr>
<tr>
<td>Anterior Instrumentation</td>
<td>22845</td>
</tr>
<tr>
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</tr>
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</table>
79 Modifier Unrelated Procedure or Service by the same physician during the post-operative period

AMA CPT Modifier Descriptor

The physician may need to indicate that the performance of a procedure or service during the post-operative period was unrelated to the original procedure.

This circumstance may be reported by using modifier 79.

79 Modifier Unrelated Procedure or Service by the same physician during the post-operative period

This is for procedures that are indicated during the post-op period and are not related to the initial surgery.

i.e.: Fusion in lumbar spine, followed by cervical discectomy within the post-op period.
79 Modifier Unrelated Procedure or Service by the same physician during the post-operative period

If the physician is required to perform a subsequent procedure or service during the post-operative period for a problem unrelated to the original surgery, the 79 modifier should be applied to the second set of procedures.

In order to use the 79 modifier, the same physician (or physician of the same specialty in the same surgical group) must perform both surgeries, even though they are unrelated.

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</tr>
<tr>
<td>Kyphoplasty @ L2</td>
<td>22524-79</td>
</tr>
</tbody>
</table>
Surgeon Modifiers

62 – Two Surgeons
80 – Assistant Surgeon
82 – Assistant Surgeon when qualified resident is not available
AS – Designates a Physician Assistant or Nurse Practitioner in surgical cases for many carriers

62 Modifier Two Surgeons (Co-Surgeons)

AMA CPT Modifier Descriptor

When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. Note: If a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.
62 Modifier Two Surgeons (Co-Surgeons)

Two surgeons working together as primary surgeons performing distinct parts of a single operative procedure. i.e. anterior lumbar interbody fusion.

Both surgeons are responsible to dictate an operative report for all codes that are billed. Post-op care is required by both surgeons.

62 Modifier Two Surgeons (Co-Surgeons)

Both surgeons should submit separate operative notes listing the same procedure code(s), with the 62 modifier appended to each code.

This indicates to the insurance carrier that 2 surgeons were involved in the case.
62 Modifier Two Surgeons (Co-Surgeons)

Each co-surgeon should submit the service at 125% of his/her normal fee schedule with the expectation of 50% reimbursement – or 62.5% of the normal or contracted fee.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Spinal Surgeon</th>
<th>General Surgeon</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterior Lumbar Arthrodesis @ L5-S1</td>
<td>22558-62</td>
<td>22558-62</td>
</tr>
<tr>
<td>Biomechanical Implant</td>
<td>22851</td>
<td></td>
</tr>
<tr>
<td>Iliac Crest Graft</td>
<td>20937</td>
<td></td>
</tr>
</tbody>
</table>
80 Modifier Assistant Surgeon

AMA CPT Modifier Descriptor

Assistant surgeon - Surgical assistant services may be identified by adding the modifier -80 to the usual procedure code(s)

80 Modifier Assistant Surgeon

A surgical assistant serves as an additional pair of hands for the primary surgeon but is not principally responsible for any parts of the surgical procedure.

The assistant must be present and involved in the actual performance of the procedure, not simply provide ancillary services.
80 Modifier Assistant Surgeon

Modifiers 80 and 82 will be reimbursed at between 15% and 25% of the allowance for the primary surgeon in most cases.

*And not every code is considered for reimbursement.*

---

80 Modifier Assistant Surgeon

It is recommended that the fee schedule submission of these codes for an assistant be reduced to 50% or less of that of the primary surgeon.

This is to avoid the possibility of denial of the claim.
82 Modifier: Assistant Surgeon when No Resident is Available

AMA CPT Modifier Descriptor

The unavailability of a qualified resident surgeon is a prerequisite for use of modifier 82 appended to the usual procedure code(s).

There may be times when a qualified resident surgeon is not available and another surgeon assists in the operation.

*In these instances, the services of the non-resident assistant surgeon are reported with modifier 82 appended to the appropriate procedure code.*

Be sure to indicate in your medical documentation or operative note that there as no resident available or capable of performing the procedure.
82 Modifier Assistant Surgeon when No Resident is Available

All of the reimbursement rules of the 80 Modifier apply to this Modifier as well.

AS Assistant Surgeon Modifiers

Medicare will make payment for an assistant-at-surgery when the procedure is covered for an assistant, non physician professional for certain spine procedures:

- Nurse Practitioner
- Physician Assistant
- Clinical Nurse

Many Commercial Carriers follow this protocol for reimbursement in cases utilizing physician extenders.
## AS Assistant Surgeon Modifiers

<table>
<thead>
<tr>
<th></th>
<th>Primary Surgeon</th>
<th>Assistant Surgeon/ Physician Extender (PA or NP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterior Cervical</td>
<td>22551</td>
<td>22551-80 or 82 or AS</td>
</tr>
<tr>
<td>Decompression and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arthrodesis C5-6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anterior Instrumentation</td>
<td></td>
<td>22845-80 or 82 or AS</td>
</tr>
<tr>
<td>Iliac Crest Graft</td>
<td>20938</td>
<td>20938-80 or 82 or AS</td>
</tr>
</tbody>
</table>

## Complication Modifiers

22 – Increased Procedural Services

78 – Unplanned Return to the Operating / Procedure Room by the same physician following initial procedure for a related procedure during the post-operative period
22 Modifier Increased Procedural Services

AMA CPT Modifier Descriptor

When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e. increased intensity, time, technical difficulty of procedure, and severity of patient’s condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.

22 Modifier Increased Procedural Services

Physician’s frequently encounter unexpected difficulty when performing surgical spine procedures. These complications often involve additional work not normally required by the physician.

In these instances, there is a significant increase in the physician’s work and time, due to the complexity of the circumstances.
22 Modifier Increased Procedural Services

One of the most abused modifiers in spine surgery; not all procedures are complicated.

Some conditions are inherent to the diagnosis, while others present increased difficulty:

i.e.: scarring with revision laminotomy case vs. excessive scarring due to history of several injections.

22 Modifier Increased Procedural Services

An automatic review or audit of any claim that includes the 22 modifier is expected, so be prepared to appeal.

Thorough supporting documentation detailing the substantial additional work performed and the reason for the additional work must be sent with each claim.
### 22 Modifier Increased Procedural Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>CPT Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterior Cervical Corpectomy with Morbidly Obese Patient</td>
<td>63081-22</td>
</tr>
<tr>
<td>Extreme Difficulty with Approach at C6-C7</td>
<td></td>
</tr>
<tr>
<td>Anterior Cervical Arthrodesis at C6-T1</td>
<td>22554, 22585</td>
</tr>
<tr>
<td>Biomechanical Implant</td>
<td>22851</td>
</tr>
<tr>
<td>Morselized Allograft</td>
<td>20936</td>
</tr>
</tbody>
</table>

### 78 Modifier Unplanned return to the operating /procedure room by the same physician following initial procedure for a related procedure during the post-operative period

**AMA CPT Modifier Descriptor**

It may be necessary to indicate that another procedure was performed during the post-operative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first, and requires the use of an operating/procedure room, it may be reported by adding modifier 78 to the related procedure. (For repeat procedures, see modifier 76).
78 Modifier  Unplanned return to the operating /procedure room by the same physician following initial procedure for a related procedure during the post-operative period

This incorporates procedures that are indicated during the post-op period.

This procedure is related to the initial surgery but was not part of the initial plan.

i.e.: Post-op wound infection, failed instrumentation

78 Modifier  Unplanned return to the operating /procedure room by the same physician following initial procedure for a related procedure during the post-operative period

Submit your claim at the full fee schedule. You can expect a reduction in reimbursement with Medicare if you use the 78 modifier.

However, it should not result in reduced reimbursement for private insurance carriers.
78 Modifier Unplanned return to the operating /procedure room by the same physician following initial procedure for a related procedure during the post-operative period

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Posterior Cervical Arthrodesis at C3-C7</td>
<td>22600-78</td>
</tr>
<tr>
<td></td>
<td>22614-78x 3 units</td>
</tr>
<tr>
<td>Posterior Segmental Instrumentation C3-C7</td>
<td>22842-78* (carrier specific)</td>
</tr>
<tr>
<td>Iliac Crest Graft</td>
<td>20937-78* (carrier specific)</td>
</tr>
</tbody>
</table>

**Service Modifiers**

26 Professional Component
26 Modifier Professional Component

AMA CPT Modifier Descriptor

Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

26 Modifier Professional Component

Many surgical spine procedures contain both a technical and professional component.

The technical component refers to the equipment, supplies, technical personnel involved in performing any procedure.

The professional component refers to the physician’s work in providing the services, the interpretation and written report associated with each procedure (i.e. reading films and interpreting diagnostic tests).
26 Modifier Professional Component

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kyphoplasty @ L2</td>
<td>22524</td>
</tr>
<tr>
<td>Fluoroscopy guidance per vertebral body</td>
<td>72291-26</td>
</tr>
</tbody>
</table>

Keep in mind when applying modifiers:

Not all modifiers will increase reimbursement, but they will explain to a carrier that the claim being submitted is different.

Communicate with individual payer regarding policy and use of modifiers.

Keep up to date on coding changes and modifier interpretations.

Keep this website handy:
Closing Comments

This course is just a primer for the new Spine Reimbursement Specialist, and additional training and research is highly recommended. Always consult with the Insurance Carrier and AMA as specific applications apply to CPT codes and the submission and reimbursement process. The information presented to you is for general educational purposes only and not intended to be considered legal positioning or opinion.

Questions?
Thank you.

Contact Us!

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